MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08381

CERTIFICATE OF DEATH

0838274 Reg. Dist. No.

1.	PLACE OF DEATH o. COUNTY Ca	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. County												
	b. CITY OR TOWN (IF RURAL ond give no Sykesvill	outside corporate limi prest town)	ts, write	Lyes. 8mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 0357.2								
	or institution Springfie	IL (If not in hospital, or Id State H				d. STREET ADDRESS 5629 0	regon A	venue		0	RESIDENCE N A FARM? NO A			
3.	NAME OF DECEASED (Type or print)	Evelyn		Middle garet Summe	rs	BARNHART	4. DATE OF DEATH	Augus		19,	Yeor 19 57			
	sex Female	6. COLOR OR RACE White	7. MARK	NEVER MARRIED DIVORCED	_	July 7, 1	.908	9. AGE (In years lost birthday)		YEAR IF U	NDER 24 HRS.			
	o. USUAL OCCUPATIO during most of worki OUSEWIFE	N (Give kind of working life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS	TRY II. BIRTHPLACE (SM	_	ountry)	1	U.S.A	HAT COUNTRY?			
13.	FATHER'S NAME					14. MOTHER'S MAIDE	N NAME							
	William Su	nmers				Ellen O	Day							
15.	n, no or unknown)) {[IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17, 18	VFORMANT		Addr						
L	No	_		•		Springfiel	d Hospi	tal Reco	rds					
		TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o	C	ne for (a), (b), and (c).]	the	cervix wit	h metas	tasis			ND DEATH			
	Conditions, if an gave rise to in couse (a), stating t lying cause fost.	mediate Dur To)											
TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I[0] 19. WAS AUTOPSY PERFORMED?													
CERTIFICATION	Manic depressive reaction, depressed type 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)													
MEDICAL	20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Yes	or 20d. II While at wor	Not while	loe. PLA	ACE OF INJURY (Home, fi tory, street, office bldg.,	orm, 20f. (City	or town)	{Co	ounty)	(State)			
	21. I certify the alive an Aug		deceas 195	ed from Deceming and that a	death	16, 1952, to accorred at 3:1	ADDRESS (SI	19, 1957 In the causes a freet, city or town, sate Hosp:	nd an the	e date si	he deceased toted above DATE SIGNED			
L	PHYSICIAN'S W	alther H.	Sonn	enfeldt, M.	D.	Sykesvi	lle, Ma	ryland		~~~~				
220	BURIAL CREMATION	8-241-	57	Headau	ERY OF	CREMATORY BY	22d. 10CA	Clerical	or county)	5	Stote)			
23.	FUNERAL DIRECTOR'S	SIGNATURE HOM	ne-C	atorwall	Th	ref. AJATE	CON RECIST	95 7 24b. RE015	TRAR'S SIGN	MATURE MAN	Heers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNER

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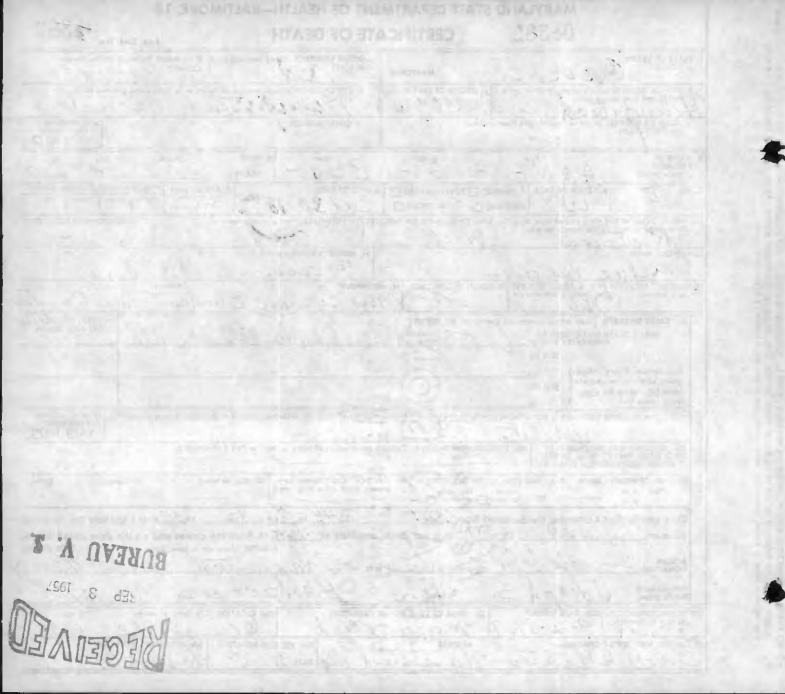
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08382 CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY filed b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate lifnits, write ELLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside/corporate limits, write RUPAL and give nearest town RURAL and give nearest town) pluous d. NAME OF HOSPITAL (If not in hospital; give street address)
OR INSTITUTION d. STREET ADDRESS 15 RESIDENCE 00 ON A FARM? YES NO Z NAME OF 4. DATE Month Year Day DECEASED (Type or print) DEATH 19-5 E wilhin S. SEX 6. COLOR OR RACE 9. AGE (In years HUNDER I YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lgs birthdoy) Months Days Hours DIVORCED T WIDOWED ID comple YES papers. 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) pou 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME гетаме ISLWAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY-NO. 17. INFORMAN 18. CAUSE OF DEATH [Enter only one couse per line-for (a), (b), and (c). INTERVAL BETWEER ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) DUE TO Conditions, If any, which gove rise to immediate ě DUE TO codie (a), stoting the underpuo lying cause lost. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT, NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES T NO. 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (State) (County) factory, street, office bldg., etc.) Hour 0. m Not while of work at work D. m. ... 19-5 Z that I last saw the deceased 21. I certify that I attended the deceased from and that death occurred at 7.36 MM, from the causes and on the date stated above. alive on ADDRESS (Street, city or Jown, stote) DATE SIGNED ACTUAL PHYSICIAN'S NAME (Type) FUNER 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. QCATION (City, town, or county) page FAQVAL (Specify) 0 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Q40. REC'D BY REGISTRAR 246. APGISTRAR'S SIGNATURE VS A15 (4) DATE 15M 9/\$\$

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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y	Vic	
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page A	may be rejained by the haspital ar attending physician. TO FUNER SIRECTOR: After this certificate has been signed by the attending physician and campletely filled the funeral director. page 3 standard for use as the burial-transit permit. Then please remove carbon papers. Pages 1 at 2 shauld be filled with the registrar priar to burial, cremation, or remayal, and in any event within 72 hours after death.	
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N A	may be rejained by the haspital ar attending physician. TO FUNER SIRECTOR: After this certificate has been signed by the attending physicion and campage 3 straight be detached for use as the burial-transit permit. Then please remove carbon pape the registrar priar to burial, cremation, or remayal, and in any event within 72 hours after death.	
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VS A15 (4) 15M 9/SS

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	a. C	CE OF DEATH	roll			YLAND	o. STATE	Mary]	Land	ived, If institutio b. COUNTY	ni Residence Ba	before odmi	ity
	R	Sykesvi	lle		2 mos 19			Balti		le limits, write RL	V o /	-4	
	0. 10	Springi:	AL (If not in hospital, ield State	Hosp	ital		d. STREET	-	way Dri	.ve		ON	A FARM?
	3. NAA DEC (Typ	ME OF EASED e or print)		thony	Middle Ni.ck		CARE	LOS	4, DATE OF DEATH	Augu		Day 5	Year 19 57
	5. SEX	lale .	6. COLOR OR RACE White	7. MARR	NEVER MARR		8. DATE OF BIR	TH		AGE (in years lost birthday) 60 yrs.		YEAR IF UNI	
-	Me	eat pack	ON (Give kind of work ling life, even if retired OF	done 10b.	- YM	OR INDU	(Greece		ntry)		en of wha	T COUNTRY
1	Ur	nkarown	Nicholas)	Unknow		hristin			
			R IN U. S. ARMED FOI (If yes, give war or dates of		SOCIAL SECURITY NO		nformant pringfic	eld Hos	spital	Records	B55		
	9 00		the under: DUE TO	Ac Ac	ute myocar ute corona terioscler	dial ry o	cclusio	n	p		Hour		D DEATH
0	5 1 200												
		TIME OF INJUR Hour a.m. p.m.		rar 20d. II While	NJURY OCCURRED Not while	20e, Pt.	ACE OF INJURY	(Home, form, ice bidg., etc.)	20f. (City or	r Iown)	{Co	unty)	(Stole)
	al	21. 1 certify that I attended the deceased from May 16, 1957 19, to August 5, 1957, that I last saw the deceased alive on August 5, 1957, and that death accurred at 1:55PM, from the causes and an the date stated above. ADDRESS (Street, city or lown, state) DATE SIGNED											
	PH	YSICIAN'S AME (Type)	Agustin de	1 Camp		100			ld Stat e, Mary	e Hospit	tal	{	3/5/57
		JRIAL, CREMATIO MOVAL (Specify)	8-9-	Other Addition	Greek 4	DETERY O	hodost		27d. LOCATIO	lemo	r county)	They	010
	23. FUR	PRAL DIRECTOR	Fucle,	5505	Harford	A.	Belto.	240. REC'D	BY REGISTRA	R 24b. REGIS	TRAR'S SIGN	NATURE J	ur

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BUREAU V. S.

		MARYLAND STATE DEPARTMENT	NT OF HEALTH—BALTIMORE, 18	00205
PI		08384 CERTIFICAT	TE OF DEATH	08385 g. Dist. No.
4		PLACE OF DEATH COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution R. o. STATE b. COUNTY)	esidence before admission)
	fi:	C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL URAL WESTMINSTER	and give nearest town)
M		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S LOCUST A VE.	3 LOCIIST AVE.	e. IS RESIDENCE ON A FARM? YES NO
00		NAME OF DECEASED RIS First Middle TATLUR	CHEW SEATH AUG	2 4 19 5
	5.	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. WIDOWED DIVORCED 4	DATE OF BIRTH 117. 13 1900 S 7 yrs.	NDER TYEAR IF UNDER 24 HRS.
_1	100	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIBUTION OF BUSINESS OR INDUSTRIBUTION OF BUSINESS OF BUSINESS OF BUSINESS OF BUSINE	11. BIRTHPLACE (State or foreign country)	2. CITIZEN OF WHAT COUNTRY
1)	13.	PATHER'S NAME NORRISTATLOR	14. MOTHER'S MAIDEN NAME FANDUE EBALL	GH.
0	IS. (Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INP. 10. or unknown) 11 yea, give wor or dates of service) 2/3-65-379	RS PAUL PETRY WES	
		19. CAUSE OF DEATH [Enter only one cause per time for (o), (b), and (o).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	monty	INTERVAL BETWEEN ONSET AND DEATH
		Conditions, if ony, which) (b) . Appelus	int	?
		gave rise to immediate cottie (a), stating the under-lying cause last.		
0	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN	PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 2
	L CERTIFI	20g. ACCIDENT WAS UNDERLYING TO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter nature of injury in Part 1 or Part II of item 18.)	
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 40c. PLACI While Not while at work at work at work	E OF INJURY (Home, farm, 20f. (City or tawn) ty, street, office bldg., etc.)	(County) (State)
		21. I certify that I attended the deceased from June alive on 24-157, and that death a	ccurred at 1:50 M, from the causes and a	at I last saw the deceased
1		ACTUAL JOTE Commette M.	ADDRESS (Street, city or town, store)	DATE SIGNED
*		PHYSICIAN'S WE CAY Jannette	MD Westminste	v md.
0	22°	BURIAL CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CORENOVAL (Specify)	CREMATORY 22d. LOCATION (City, town, or cou	nty) (State)
	180	FUNERAL DIRECTOR'S SIGNATURES / ADDRESS /	240. REC'D BY REGISTRAR 24b. REGISTRAR	C MCNIATINGE

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B "N DVBEAU Y. R.



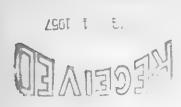
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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		08386	CERTIFIC	ATE OF DEAT	H Reg	. Dist. No.				
	. PLACE OF DEATH 6. COUNTY	•	MARYLAND	MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution Residence of STATE by COUNTY						
	RURAL and give ne				outside corporate limits, write RURAL	and give nearest town)				
-	d. NAME OF HOSPI	AL (If not in hospital, give i	IB ==3	Sykesy:	III.le	e IS RESIDENCE				
	OR INSTITUTION	ield State H		Gaither R	d,box 82	YES NO				
	NAME OF DECEASED (Type or print)	Robert	Middle Charles	COURSEY	4. DATE Month OF DEATH August	Doy Yeor 11 1957				
	S SEX		MARRIED NEVER MARRIED DOWED DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday) 86 yrs.	ths Doys Hours Min.				
, -	100 USUAL OCCUPATION	1 24.4	106 KIND OF BUSINESS OR INDE	JSTRY 11. BIRTHPLACE (Stote		CITIZEN OF WHAT COUNTRY?				
1	during most of worl	king life, even if retired)	agricultur	- Marylan		U.S.A.				
ŀ	3 FATHER'S NAME			14 MOTHER'S MAIDEN	NAME					
4	R. Henr	V COURSEY		Rosanne	Lenon					
	WAS DECEASED EVE	R IN U. S ARMED FORCES		INFORMANT	Address					
	no		.	Springfield S	tate Hospital,-Syl	cesville. Md.				
	18. CAUSE OF DEA		per line for (a), (b), and (c)]			INTERVAL BETWEEN				
Ŧ	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Heart failure	arterios cle	rotic heart diseas					
Т	420.0	DUE TO				3 weeks				
ł	Conditions, if o		Bronchomeumo	nia						
1	gove rise to immediate cause (a), stating the <u>under.</u> DUE TO									
1	lying couse lost. 441× (c) dehydration									
1	PART II. OT	HER SIGNIFICANT CONDITI	ONS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERM	WITHASPEDENIOFIENIN	METTON WAS AUTOPSY				
1	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE HAS SOUTH THE THE WAS AUTOPSY CBS, associated with disturbance of metabolism, with senile brain diseased No File									
	200 ACCIDENT WAS OR CONTRIBUTING		DESCRIBE HOW INJURY OCCURR	ED (Enter noture of injury in	Port I or Port II of item 18.)					
	ZOc. TIME OF INJUR Hour a. m. p. m		20d. INJURY OCCURRED 20e. 9 White Not while for work of work	LACE OF INJURY IHome, for octory, street, office bldg, et	m, 20f. (City or town)	(County) (State)				
	21. I certify th	at Lattended the de	ceased from 1-21-5	6, 19, 10.A	ugust 19.57. tho	t I last saw the deceased				
		gust			PM, from the causes and a					
		1	/		ADDRESS (Street, city or town, stote)	DATE SIGNED				
1	ACTUAL SIGNATURE	: man	work -	MD Springfi	eld State Hospital	8-12 - 57				
	PHYSICIAN'S NAME (Type)	Martin Gros	ss, M. D.	- Sykosyri I	7a. V4.					
	220. BURIAL, CREMATIC	ON, 226. DATE THEREOF	MA PERSON TO STATE OF CEMETERY	, <u> </u>	22d LOCATION (City, towns or cour	Here (Stote)				
-	23. FUNERAL DIRECTOR	S SIGNATURE C	ADDRESS	acc.	C'D BY REGISTRAR 246 REGISTRAR	S SIGNATURE				
1	Luther	A. Hoight	Sykesirlle	Mal DATE &	3/12/57 6.24	my Teleer				

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



BUREAU V. E.

										Reg. D	ist. No.		/ /
1. PLACE OF DEATH o. COUNTY						2. USUAL I	ESIDENCE (W	hera decease	d lived. If instituti		nce befor	e odmis	sion)
Carro	1			MARY	/LAND	o. STATE	Maryl	and	b. COUNTY	Balt	imor	e Ci	Ltv
b. CITY OR TOWN (I RURAL and give no	f autside carporate limi	ls, write	c. LENGT	H OF STAY	IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Sykesville			25	days		Balt	imore	13. Md		1			
d. NAME OF HOSPIT	AL (If not in hospital, g	jive street	oddress)				ET ADDRESS					. IS RES	SIDENCE A FARM?
Springfield						1514	N. Reg	ester	Avenue				NO []
3 NAME OF DECEASED	Fir	ta ta		Middle			Last	4. DATE	Mor	oth	Da	y	Year
(Type or print)	Georg	e		Thom	nas		urtis	OF DEATH	8		31		1957
5. SEX	6. COLOR OR RACE	7. MARR	IED NE	VER MARRI	ED 🔲	8. DATE OF E	IIRTH		9. AGE (In years last birthday)				ER 24 HRS
M	W **	WIDOWE	_	DIVORCE	_ ;	unkno			65 % yrs.	Months	Days	Hours	Min,
10a. USUAL OCCUPATION during most of work	ON (Give kind of work	done 10b.	KIND OF B	BUSINESS C	OR INDU	TRY 11. BIRT	HPLACE (State	ar fareign c	ountry)	12. CI	TIZEN O	F WHAT	COUNTRY:
carpent	er	H	lome	Cons	truc	tion	Maryl	and			U.S.	A.	
13. FATHER'S NAME						14. MOTH	ER'S MAIDEN	NAME					
]	evi Curtis	_					Annie	Brueh	1				
IS. WAS DECEASED EVE	R IN U. S. ARMED FOR	ervice)	SOCIAL SE			NFORMANT			Add	ress			
no		23	16-05-	-0938	S.S	Hospi	tal Re	cords					
	TH [Enter only one co				-							RVAL BE	
PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	Arte	erioso	clerot	tic l	neart d	lisease				ye	ars	DEATH
4000	DUE TO												
Canditions, if a		1											
gove rise to is													
lying cause last.		}					*****						
PART IL OTH	IER SIGNIFICANT CON							INAL DISEAS	E CONDITION GIV	EN IN PAR	T 1(o) 19	WAS	AUTOPSY OPMED?
3 Involuti	ona psycho	tic r	reacti	ion, I	Piabe	etes me	llitu					YES	NO 🚰
O HIE EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW	INJURY O	CCURRE). (Enter natu	re of injury in	Port I or Par	t () of item 1B)				
20c. TIME OF INJUR	Y Month, Doy, Yes		NJURY OCC		20e. PL/	CE OF INJUI	RY (Home, form	20f. (City	r or town}	(County)		(Stote)
Hour c. ji.	19	While of work	k 🔲 at wo	vhile rk 🔲	100	nory, sireer, o	THER DIOG., BIC	1					
21. I certify th	at I attended the	decease	ed fram	8-6-		, 19 5	7 . ta	8	-31-, 1957	that I	last sa	w the	decensed
alive on	8-31-	1957							n the causes o				
1	/	0	1.0		4000	***************************************		ADDRESS (S	treet, city or town,	stote)	ne das		ATE SIGNED
SIGNATURE Zd	rucered .	Zu	sth	an	->	u.o. Spri	ngfield	d Stat	e Hospit	al		8-	-31 - 57
PHYSICIAN'S NAME (Typo)	Edmund Inc					Syke	sville	_Md_	س بين سند مند سند سند وي هند سنز مند مند شاه مله مند				ين د جب الله د د د الله
220. BURIAL, CREMATIO REMOVAL (Specify)	N. 22b. DATE THEREC	F				CREMATOR			TION (City, town, o		20	{Shar	
Burial	9-3-57				ck	Bapti	st	But.	ler, Ba				•
23 FUNERAL DIRECTOR	SSIGNATURE	P.	ADDR	1	21.	P.	24a. REC*	D BY REGIST	RAR 24b. REGI	STRAR'S SH	BNATUR	E 1	P
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	17 17M7 1 \ 1	11 200 .	- T 2 18 m		11 11 1	# / 9	Town 1970s Inc.		4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	211		W7	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death: Page 4

may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3: And be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 should be filed with

DEALES EN

BUREAU V.

FOR STATE HEALTH DEP director. Page for your files. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is execute '9's certificate writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the furning should be taken to be supported to the Chief Medical Examiner's Office along with farm PM3. Pages 5 may be reto to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Station is to figure against a permit only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 08388

MEDICAL EXAMINER'S CERTIFICATE OF DEATI

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nstiluli			before a	dy issign)	ir.

۲. ا	1. P		USUAL RESIDENCE (Where deceased lived If institution Residence before advission)
	0	- COUNTY /	· STATE Maryland COUNTY Back City
	b	b. CITY OF TOWN III outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 cog give nearest town) List (Classicalle 2 years 8 days)	c. CITY OR TOWN (If orbide corporate limits, write RURAL and give necrest town)
	46	M. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, the street address)	STREET ADDRESS 24 to ST. IS RESIDENCE ON A FARM? VES NO SK
	(OFCEASED (Type or print) Jane Bell	Derland DEATH B 3 1957
45,000	5. 5	SEX 6. COFOR OR RACE 7. MARRIED NEVER MARRIED B DA. WIDOWED DIVORCED X 1	TE OF BIRTH O-26-92 AGE (In year) If UNDER 1YEAR IF UNDER 24 Hts Another Days Hours Min.
	100	Do RUSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY doing most of working life even if retired)	11. BIRTHPLACE (Stole or foreign country) Scotland 12 CITIZEN OF WHAT COUNTRY?
	13.	William Rusell Bell 14.	Mother's Maiden Name Regers
•	15 (Yes	5 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INTO 17 INTO 17 INTO 17 INTO 17 INTO 18 I	on tal Recentle
예	MOIL	18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if ony, which gove cise to immediate course (o), aloting the underlying course lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT I	latory accident INTERVAL BETWEEN ON PART 1(0) 19. WAS AUTOPSY PERFORMED PROPERTY OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED PROPERTY OF THE DEPTH INDICATE OF THE PART INDICATE OF THE
	L CERTIFICATION		
	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 While Nat while of work all work 19 declary.	F INJURY (Home, form, 20f (City or town) (Caunty) (State) street, affice bldg., etc.)
		21. I certify that I took charge of the remains described above, opinion death resulted from: Natural causes . Accident .	Suicide [], Homicide [], Undetermined manner []
		ACTUAL SIGNATURE ESCUELS J. March M.	D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER
	270	NAME (Type) CAMES 1. 17075/7	DEPUTY MEDICAL EXAMINER (City Jown, or county) (Stole)
		Therend 8-6-57 Oak faws	240. REC'D BY REGISTRAR 24b. REGISTRAR'S S CHATURE
	9	John Ullride - 4210 Beller Rd. Bale	8-4 DATE 8-3-57 C. Harry Elech

VS A15ME 5M 2757

TAGEDALL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 08389 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a COUNTY **b.** COUNTY MARYLAND Carroll Marvland Balto.City b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)
Sykesville 20vrs. 3mos. Lidavs Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS . 15 RESIDENCE OR INSTITUTION Springfield State Hospital 1317 W. Fayette St., Balto. YES NO D NAME OF Middle Yeor DECEASED William FLMUNDS 1957 Hovey DEATH August (Type or print) 9. AGE (in years lost birthday) 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX Months Days Hours 1870 Male White DIVORCED [WIDOWED | 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? Rooming-House Keeper & Mechanic U.S.A. New York 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address No Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Arteriosclerotic Heart Disease 420.0 DUE TO Generalized Arteriosclerosis Years Conditions, if gay, which gove rise to immediate **DUE TO** couse (o), stoling the underlying couse lost. Paranoid reaction, paranoia, -Arterial embolism and thrombosis of the performed? YES NO NO 20b DESCRISE HOW INJURY OCCURRED, (Soler nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING TO CAUSE OF DEATH 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, farm Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (Stote) (County) factory, street, office bldg., etc.) Not while of work of work 21. I certify that I oftended the deceased from, March 7. , 1955 , to August 3. 157 that I last saw the deceased ____, and that death occurred at 10:10AM, from the couses and on the date stated above. ADDRESS (Street, city or town, stote) Cru Do, MD ACTUAL Springfield State Hospital PHYSICIAN'S Agustin delCampo Sykesville, Maryland NAME (Type) 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City fown or county) (Stole) REMOVAL (Specify) 0 246 REGISTRAR'S SIGNATURE 240 REC'D BY REGISTRAR VS A15 (4)

DECENTE

BUREAU V. S.

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VS A15 (4) 15M 9/55

	083	90	CERTIF	ICA	TE OF DEATH			Reg. Dist.	839	174		
1	PLACE OF DEATH COUNTY Carroll		MARYL	AND	2. USUAL RESIDENCE (Where deceased tived. If institutions Residence before admission a. STATE Maryland b. COUNTY Balto. City							
	b CITY OR TOWN (If authide corporate in RURAL and give represt form) Sykesville	mits, write	Limos . 10day:		e. CITY OR TOWN (If ou Baltimore		rate limits, write RU	JRAL and giv	re negrest	fown}		
	d NAME OF HOSPITAL (If not in hospital, OR INSTITUTION Springfield State	give street Hospi	oddress) tal		d. STREET ADDRESS 3153 Lyndal		IS RESIDENCE ON A FARM? YES NO TO					
	NAME OF DECEASED (Type or print) Cath	Smith Do	nnet		4. DATE OF DEATH	Augu		26,	Year 57			
5. 9	Female White	7. MARI	RIED NEVER MARRIED DIVORCED		October 20,18	367	9 AGE (In years last) by thday) yrs.			INDER 24 HRS		
	USUAL OCCUPATION (Give kind of wer during most of working life, even if return Housewife	k dane 10b	KIND OF BUSINESS OR	INDUS	Scotland		iuntry))	S.A.	HAT COUNTRY?		
13	FATHER'S NAME				14 MOTHER'S MAIDEN NA	AME						
	John Donnet				Catherine	Ande	rson					
15	WAS DECEASED EVER IN U. S ARMED PO		SOCIAL SECURITY NO.	17. IN	IFORMANT		Addre	233				
(1,4)	No -	10.74.01	-	St	oringfield Hos	pital	Records					
	18. CAUSE OF DEATH [Enter only one	cause per li	ne for (a), (b), and (c).]						INTERVA	L BETWEEN		
	PART 1. DEATH WAS CAUSED BY	. Д		otio	heart diseas	ie.			ONSET	ND DEATH		
	IMMEDIATE CAUSE	(0)										
	Conditions, if any, which)											
	gove rise to immediate (NIS YO									-		
	couse (a), storing the under-											
z	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY											
190	C.B.S. with senile brain disease with psychotic reaction.									REORMED?		
D.	200 ACCIDENT WAS UNDERLYING				psychootic real				YES	П ио		
L CERTIFICATION	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER	H }										
MEMICAL	20c TIME OF INJURY Month, Day, 1 Hour a.m. p. m 19	While		PLA fac	CE OF INJURY (Home, form, lary, street, affice bldg., etc.)	20f. (City	ar town)	(Co	unty)	(State)		
	21. I certify that I attended th	e deceas					6, 1957					
	alive on August 25.	, 192	and that a	ieath	accurred at 3:34A				date s			
	ACTUAL Walful H	Jon	11/11delde	5.	Springfie	,	reet, city or town, state Hosp	,		8/26/57		
	PHYSICIAN'S Walther H.	Sonn	enfeldt, M.	D.	Sykesvill	Le, Ma	ryland					
A	BURIAL CREMATION, 226 DATE THER REMOVAL (Specify)	8/57	200 CEMET	ERY OF	in	Nov	ion (Gry, lown, o	100	10	(State)		
23	FUNERAL DIRECTOR'S SIGNATURE	2755	mater 490	5	ort Range St	AY REGIST	RAR 246 REGIS	TRAR'S SIGN	NATURE	RAA		
Name of Street				1	+			The way		7		

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



CERTIFICATE OF DEATH 08391 Reg. Dist. No. KI PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed. If institutions Residence before admission) O STATE a COUNTY b. COUNTY filed MARYLAND Marvland Howard Carroll b. CITY OR TOWN IIf outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN IIf outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) L8yrs.7mos.17days Sykesville Hvattsville. d NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d STREET ADDRESS e. IS RESIDENCE Springfield State Hospital 1:01 Greenlawn Drive. YES NO D NAME OF First Middle 4. DATE Month Lost Year DECEASED 1057 pletely filled Sol PRIEDKIN August DEATH (Type or print) 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 1 8. DATE OF BIRTH 9. AGE [In years IF UNDER TYEAR IF UNDER 24 HRS. 5. SEX 1884 Jast birthday) Months Mala White WIDOWED | DIVORCED [100 USUAL OCCUPATION [Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? ELOD during most of working life, even if retired) Unknown Russia Jeweler corbon 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Hendin Frank Friedkin 17. INFORMANT 15 WAS DECEASED EVER IN U. S ARMED FORCES? 16. SOCIAL SECURITY NO No Springfield Hospital Records. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Minutes Acute coronary occlusion IMMEDIATE CAUSE (o) 400.0 **DUE TO** Years Arteriosclentic heart disease Conditions, if onv. which gave rise ta immediate **DUE TO** couse (a), stating the under-Years Generalized arteriosclerosis lying couse last Schizophrenia, hebephrenic type. 19 Was autopsy YES NO 🔼 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part II or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, 20f (City or town) 20d, INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour a.m Not while of work at work August 9, 50 21. I certify that I attended the deceased from July 1957 that I last saw the deceased alive on August 9 and that death accurred at 8:30A_M, from the causes and an the date stated above DATE SIGNED ADDRESS (Street, city or town, state) 8/9/57 Springfield State Hospital ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D. Sykesville. Maryland. NAME (Type) FUNER 274 NAME OF CEMETERY OR CREMATORY 220. BURIAL, CREMATION, 22b DATE THEREOF 22d LOCATION (City_town, or county) (State) 0 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 246. REGISTRAR'S S'GNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

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BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08392CERTIFICATE OF DEATH Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed **b.** COUNTY Carroll MARYLAND Carroll Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) RURAL and give nearest town) Woodbine mo. Svkesville d NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d STREET ADDRESS OR INSTITUTION Pullen Nursing Home YES NOT NAME OF 4. DATE Middle Month Day Year DECEASED OF DEATH 1957 August (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years 5 SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED PA lost birthday) Months Days Hours white WIDOWED [DIVORCED | female yes papers. 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) during most of working life, even if relired) 12. CITIZEN OF WHAT COUNTRY? death. U.S.A. Marvland home housework carbon 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Anne Jesse Gosnell 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Bal to 3127 Ravenwood Ave., Donald Gosnell. none INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per lige for (a), (b), and (c).] ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** cotse (o), stating the underlying couse last. PART IL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO 1 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, Day. Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o.m. White Not while at work 🔲 at work p, m, 1957 that I last saw the deceased 21. I certify that I attended the deceased from and that death occurred at 2P. M. from the causes and an the date stated abave. alive on CTOR ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) E. HALL HOWARD 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY (FIRE 22d. LOCATION (City, town, or county) T. 2. (Stole) Morgan Chapel Carroll Co., Maryland 0 REC'D BY REGISTRAR THE REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** Winfield, Maryland C. M. Waltz. VS A15 (4) 15M 9/SS

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	08393	CERTIFICA	AIE OF DEATH	Reg. Di	1st. No. 74
1. PLACE OF DEATH o. COUNTY	Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceosed o. STATE D. C.	lived. If institution, Resider b. COUNTY	nce before admission)
b. CITY OR TOW RURAL and giv	N (If autside carporate limits, wri e nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corpore	ote fimits, write RURAL and	give nearest town) 🔍
	Henryton	232 days	Washington	4. 1	
d. NAME OF HO OR INSTITUTION	SPITAL (If not in haspital, give str	eet address)	d. STREET ADDRESS		e. 15 RESIDENCE ON A FARM?
	Henryton Stat	e Hospital	228 - 10th Str	reet, N.E.	YES NO
3. NAME OF DECEASED	First	Middle	Lost 4. DATE	Month	Day Year
(Type or print)	David	McKinley	Gray, Jr. DEATH	August	7 1957
S. SEX	6. COLOR OR RACE 7. M	ARRIED NEVER MARRIED	8. DATE OF BIRTH	last birthdoy) Months	TYEAR IF UNDER 24 HRS
Male	Negro wick	OWED DIVORCED	Sept. 25, 1925	31 yrs	Days Hours Min
10a. USUAL OCCUP.	ATION (Give kind of work done) I working life, even if retired)	106. KIND OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (State or fareign cau	intry) 12. Ci	TIZEN OF WHAT COUNTRY
	nitor	Restaurant	High Point, N.	C.	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
	David Gray, S	r.	Victoria Stewa	art	
	EVER IN U. S ARMED FORCES?		INFORMANT	Address	
(Yes, no or unknown)	(If yet, give wer or dates of service)	2hh-30-8905	David McKinley Gray,	Jr Patie	ent
	DEATH [Enter only one couse po				INTERVAL BETWEEN
	DEATH WAS CAUSED BY:	Hemorrhage, lun	σ		ONSET AND DEATH
voax		remorriages turi	5		
		Com adversed cov	itary pulmonary tube	amoull not a	
gove rise to	immediate (ar auvanced cav	Loary parsionary cube) CULOSIO	
lying cause to					
	107	NS CONTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMINAL DISEASE	CONDITION CIVEN IN PAI	T I(a) 19 WAS AUTOPSY
5	OTTER STORM ICART CORDING	13 CONTRIBOTINO TO DEATH BO	THO RESIDENCE PROPERTY	CONDITION GIVEN IN TAI	PERFORMED?
200 ACCIDENT	MAS UNDERLYING CT 20%	DESCRIBE MOW NUMBER OF CURBIN	ED (Enter nature of injury in Part I or Part	th of them 18)	YES NO
PART 11. 200 ACCIDENT OR CONTRIBUT (IF EITHER, NO1	WAS UNDERLYING 20b. ING CAUSE OF DEATH	DESCRIBE HOW INJURY OCCORRI	(chier noture or injury in roll or roll	ii or nem is j	
		4 h 1 1 1 2 4 2 5 1 2 6 2 6 1	ACT OF INDIRA MARKET TOOL ICA		10
ZOC. TIME OF IN Hour o.	m. Wi	hele Not while fo	LACE OF INJURY (Mome, form, 20f (City octory, street, affice bldg., etc.)	or town) ((County) (Stole)
	,	work at wark			
21. I certify	that I attended the deci	eased from 12-17-		, 19. <u>57</u> ,that f	last saw the deceased
alive on	8-7-	257, and that deat	h occurred at 10:50A M, from	the causes and on t	the date stated above
	1			eet, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE	4 13 Proces	, to 2	M.D. Henryton, Ma	aryland	8-7-57
		/			
PHYSICIAN'S NAME (Type)	Edgars M. Macu	lans, M.D.	Henryton State	Hospital, Her	ryton, Md.
	TION, 226. DATE THEREOF	22c. NAME OF CEMETERY O	OR CREMATORY 22d LOCATE	ON (City town, or county)	(State)
REMOVAL (Spe	8-13-57	artion	to not a	Single.	- Wa
23. FUNERAL DIRECT		ADDRESS	240. REC'D BY REGISTR	AR 246 REGISTRAR'S ST	GNATURE
A V		1000	1 1 1 9 0 57	11/11/11	/

y the funeral director, 2 should be filed with TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attained by the haspital or attending physician.

TO FUNER POSSECTOR: After this certificate has been signed by the attending physician and completely filted page 3 for 3 d be detached for use as the burial-transil permit. Then please remove carbon papers. Pages 1 the registrar prior to burial, cremation, or removal, and in any event within 72 hours offer death.

VS A1S (4) 15M 9/55

BUREAU V. E.
Aug 12 1957

24a, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

ADDRESS

Westminster, Maryland DATE 8

TO HOSPITAL

TO HOSPITAL

TO FUNES

A 12 (4)

TO FUNES

A 12 (4)

23. FUNERAL DIRECTOR'S SIGNATURE

John R. Byers

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BUREAU V. S.

PAGE A P. DOA

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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PLACE OF DEATH Reg. Dist. No. 74	4				D STATE DEPARTA	MENT OF HEAL	TH-BALTIMORE,	18 08398 /
Description of the state of th	1		7	08396	CERTIFIC	ATE OF DEA	TH	TH
CATTOLION COMPANIE CONTROL COMPANIE CONTROL COMPANIE CONTROL COMPANIE CONTROL CONT	P	Ţī	PLACE OF DEATH			2. USUAL RESIDENCE	Where deceased lived. If institut	lion: Residence before admission)
Sykes ville Lyy - Smo - 29 da Frederick	/	L		rroll	MARYLAND		yland b. COUNT	Frederick
Sylesyille ANNA CO			b. CITY OR TOWN	(If outside corporate limits, write	E. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write	RURAL and give nearest town)
Springfield State Hospital Springfield State Hospital Springfield Sta			Sykesv	ille	Lyr.8mo.29da	Fre	derick /	
Springfield State Hospital 105 W. 1th Street 105 M. 1			d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital, give stre	et oddress)	d. STREET ADDRESS		IS RESIDENCE ON A FARM?
DECEASED	10		Spring	field State Hos	spital	105 W.	hth Street	
S. SEX		3.	NAME OF DECEASED				4. DATE Mo	
Male White widowed Divorced 8-25-72 804 yr. Months Doys Hours Mile 100. USUAL OCCUPATION (Give kind of work done) 100. KIND OF BUSINESS OR INDUSTRY 11. BYTHPLACE (Sieve or foreign country) 12. CITIZEN OF WHAT COUNTE 13. FATHER'S NAME La. MONHEY'S MAIDEN NAME La. MONHEY'S MAIDEN NAME Marry Baker La. MONHEY'S MAIDEN NAME La. MONHEY'S MAIDEN NAME Marry Baker La. MONHEY'S MAIDEN NAME La. MONHEY'S MAIDEN NAME Marry Baker La. MONHEY'S MAIDEN NAME La. MONHEY MONHEY La. MONHEY M			(Type or print)					
100. USUAL OCCUPATION (Gree stand of work done) Brick Contractor 12. FATHER'S NAME JOSHUB James 13. MAY DECEASED VER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT JOSHUB JAMES 15. WAS DECEASED VER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT JOSHUB JAMES 18. CAUSE OF DEATH (Enter only one course per line for (o), (b), and (c). 19. PART I. DEATH WAS CAUSED BY. Old Recumental Control of the Control o	3/	5		7700 0 1			9. AGE (In years lost by rinday)	Months Dovs Hours Min
Brick Contractor 13. FATHER'S NAME JOSHUA JAMES 15. WAR DECEASEDEREN IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT NOTHER'S MAIDEN NAME Mary Baker 15. WAR DECEASEDEREN IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Springfield State Hospital - Sykesville, Md. 18. CAUSE OF DEATH (Enter only one course per fine for [6], [b]), and [c].] PART I. DEATH WAS CAUSED BY. Old Fineumatic heart disease plus Conditions, if ony, which gover rise to immediate course [6], bronchopnoumonia DUE TO Conditions, if ony, which gover rise to immediate course [6], bronchopnoumonia Chronic brain syndrome, circulatory disturbance, cerebral arterio- PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(6) 19 WAS AUTOFY Chronic brain syndrome, circulatory disturbance, cerebral arterio- PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(6) 19 WAS AUTOFY Chronic brain syndrome, circulatory disturbance, cerebral arterio- PREFIGMENT TO SCIENCE OF HAUDEY MORPH, DOY, Yor Took HAUDEN COURSED [Enter noture of minury in Part I of Fort II of from II b) TO CHITTEN COURSE MICH COLUMNER TO SUBJECT TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Enter noture of minury in Part I of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, Yor Took II of HAUDEN COURSED [Course of Inition II of Item IB] TO THE OF HAUDEY MORPH, DOY, YOR TOOK II of INITION COURSED [Course of Inition II of Item IB] TO THE OF H	I)							
13. FATHER'S MANDE JOSHUA James 14. MOTHER'S MAIDEN NAME Mary Baker 15. WAS DECEASED EVER IN U. S. ARMED FORCEST 16. SOCIAL SECURITY NO 17. INFORMANT 17. INFORMANT Address Mary Baker 18. CAUSE OF DRAIM (Enter only one course per line for [o], [b]), and [c].] 19. FATIL DEATH WAS CAUSED BY. Old Rheumatic heart disease plus INTERVAL BETWEEN ONSET AND DEATH 19. FATIL DEATH WAS CAUSED BY. Old Rheumatic heart disease plus INTERVAL BETWEEN ONSET AND DEATH 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to immediate 19. DUE TO Conditions, if any, which gove rise to disease plus range rise to immediate 19. DUE TO Conditions, if any, which gove rise to disease plus range rise rise for any part 19. DUE TO Conditions rise rise rise rise rise for any part 19. DUE TO Conditions rise rise rise rise rise rise rise ris		ıl"	during most of wo	rking life, even if retired)	%. KIND OF BUSINESS OR INDI	USTRY [11. BIRTHPLACE (SI	ole or foreign country)	
Joshua James Is was diceasedever in u. S. Armed Forces? Is. Social Security no It. Informant Springfield State Hospital - Sykesville, Md. Is. Cause Of Death [Enter only one couse per line for [e], [b], and (c). Springfield State Hospital - Sykesville, Md. Is. Cause Of Death (Enter only one couse per line for [e], [b], and (c). Part I, Death was caused by Old Rheumatic heart disease plus Part I, Death was caused by Old Rheumatic heart disease plus Conditions, if any, which gove rise to immediate couse (e). Bronchopnoumonia (b). Due to (c). Isolain the under the couse of the disease plus of the terminal disease condition given in part I(e) if was autober the couse (e). Isolain the under the couse (e). Isolain the under the	9			ontractor				U.S.A.
S. WAS DICEASE EVER IN U. S. ARMED PORCEST 16. SOCIAL SECURITY NO 17. INFORMANT Spring field State Hospital - Sykesville, Md.		TI:		_				
Springfield State Hospital - Sykesville, Md.								
IB. CAUSE OF DEATH [Enter only one couse per line for [o], [b], and [c].] PART I. DEATH WAS CAUSED BY. OLD TO Conditions, if only, which gove rise to immediate lough the process of th		-10	res, no. or unknown)	(If yes, give wor or dates of service)				
PART I. DEATH WAS CAUSED BY. Old Rheumatic heart disease plus Conditions, if ony, which gover itse to immediate course (ol.), testing the under course (ol.), testing the under bying course lost. (c)	د.					Springfield S	State Hospital	
DUE TO Conditions, if ony, which gove rise to immediate couse (o), storing the under thing couse is it. If (s) Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPY Chronic brain syndrome, circulatory disturbance, cerebral arterio— Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPY CHronic brain syndrome, circulatory disturbance, cerebral arterio— PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 PREFORMED PREFORMED PROPERTY OF CONTRIBUTIONS (Chronic brain syndrome, circulatory disturbance, cerebral arterio— PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 PART		П	18. CAUSE OF DE	ATH [Enter only one couse per	r line for (o), (b), and (c).)	rt disease n	1119	INTERVAL BETWEEN
Conditions, if ony, which gove rise to immediate proverise to immediate provering the under the provention of the		П	PART I. DE	IMMEDIATE CAUSE (0) By	onchopneumonia-	TO GEOGGE P	J. (42)	2-3 days
gove rise to immediate couse (a), storing the under- tying couse lost. IC		П	4					
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20g ACCIDENT WAS UNDERTYING DO CONTROL 206 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item IB) 20g ACCIDENT WAS UNDERTYING DO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20g CONTROL CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21 LIMPACIAL CREMATION (22b DATE THEREOF MEDICAL EXAMINER) 220g BURIAL CREMATION (22b DATE THEREOF MEDICAL EXAMINER) 221 LIMPACAL DIRECTOR'S SIGNATURE 222 DATE THEREOF MEDICAL EXAMINER) 223 ELIMPACAL DIRECTOR'S SIGNATURE 224D REC'D BY REGISTRAR (24b REGISTRAR'S SIGNATURE) 224D REC'D BY REGISTRAR'S SIGNATURE		Z			IS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TEL	RMINAL DISEASE CONDITION GI	IVEN IN PART YOU TO WAS AUTOPSY
20a ACCIDENT WAS UNDERTYING 12b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (Mile Not while of work of	3	ATA					ce, cerebral ar	terio- PERFORMED?
20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED While Not while of work of the wo			20g ACCIDENT W	AS UNDERLYING TO 1986 B	FCHOTIC POSCULO ESCRIBE HOW INJURY OCCURR	ED (Enter noture of injury	in Port I or Port II of item 1B	
21. I certify that I attended the deceased from November 5, 1952, to August 1, 1957, that I last saw the decease alive an August 1, 1957, and that death accurred at 1325A.M. from the causes and on the date stated above ADDRESS (Sireet, city or town, state) ACTUAL SIGNATURE M.D. Springfield State Hospital 8-5-5' PHYSICIAN'S NAME (Type) Martin Gross, M.D. Sykesville, Maryland 220 BURIAL CREMATION. 22b DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote) PEMOVAL (Specify) Syle 5 Martin Gross, M.D. Sykesville, Maryland (Stote) 23 FILIPERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE		18	OR CONTRIBUTION	G [] CAUSE OF DEATH Y MEDICAL EXAMINER)				
21. I certify that I attended the deceased from November 5, 1952, to August 1, 1957, that I last saw the decease alive an August 1, 1957, and that death accurred at 1325A.M. from the causes and on the date stated above ADDRESS (Sireet, city or town, state) ACTUAL SIGNATURE M.D. Springfield State Hospital 8-5-5' PHYSICIAN'S NAME (Type) Martin Gross, M.D. Sykesville, Maryland 220 BURIAL CREMATION. 22b DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote) PEMOVAL (Specify) Syle 5 Martin Gross, M.D. Sykesville, Maryland (Stote) 23 FILIPERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE		3	20c. TIME OF INJU					(County) (State)
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alive an August II , 1957 , and that death accurred at 11325A. M., fram the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE					gred from November	5 1052 10	Angust 1 105	7 that I last saw the decays
ACTUAL SIGNATURE Nach Superior		L						
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NAME (Type) Nartin Gross, M. D. Sykesville, Maryland 220 BURIAL CREMATION, 22b DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, Town, or county) (Store) 23 ELIDERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE	1	П				.mumgesenges	**************************************	#1444
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23 FILDJERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAY'S SIGNATURE		2		ON, 225 DATE THEREOF				or county)(Stote)
100 40 10 1200		1	Burney	8/6/57	-/ -/ /	net	Freder	A mad
H. C. Coulifer Frederich Mg DATE Charry Gely		23	FILLERAL DIRECTO	R'S SIGNATURE	ADDRESS	-7 / 240 RI	EC'D BY REGISTRAR 24b REG	ISTRAR'S SIGNATURE
1020		2	4.2.60	ulipleo 1	Tredent	MAG DATE		C Harry Hees.
		-				1	10:57	100

DECENALLY SERVICES

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BECEINE

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08398FOR STATE Rea. Dist No. HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. COUNTY files. Heolth, b. courarroll Carroll MARYLAND b. CITY OR TOWN III outside corporate limits, write RUSAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) and give negrest town) Tanevtown 2moTanevtown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS NAME OF Middle 4 DATE Month Doy DECEASED OF (Type or print) RALPH LOOKINGBILL AUG. DEATH 6. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8 DATE OF BIRTH IFUNDER TYEAR IF UNDER 24 HRS 9. AGE (to years lost birthday) Months Doys 5 male white WIDOWED DIVORCED [7] 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Slole of foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) in school Maryland U.S. ile pages # Poges m PM3. 13. FATHER'S NAME 14. MOTHER 5 MAIDEN NAME Aubrey Lookingbill Ethel M. Watson form File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. G Aubrey Lookingbill, none R.D. Mt. Airy, Md. 18 CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: UFFOCATION- by IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to 'mmediate cause DUE TO (a), stating the underlying couse lost PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS ALTOPSY 0 200. EXTERNAL CAUSE WAS PRIMARY SLOT CONTRIBUTING CAUSE OF DEATH. 206 DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of Item 18) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 120f, (City or town) Month, Doy, Year (County) fectory, street office bldg , etc) White Nat while of wark at work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection 12. Inquiry N. opinion death resulted from Notural causes 1. Suicide X, Accident . Homicide . Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Shor 220 BURIAL CREMATION 226 DATE THEREOF 22d LOCATION (City, town, or county)

orsville

ADDRESS

Winfield, Maryland

e. IS PESIDENCE ON A FARM? YES NO

Year

1957

Hours

Munita

PERFORMED?

NO TO

(State)

and in my

DATE SIGNED

Co. Maryland

Carroll

240 REC'D BY REGISTRAR

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23 FUNERAL DIRECTOR 5 SIGNATURE

Waltz.

BUREAU V. R.

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CERTIFICATE OF DEATH

Reg. Dist. No.

gar.	_												
1		PLACE OF DEATH	-mu-17			MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Balto-City						
- A		b. CITY OR TOWN (IF	outside corporate	hmils, write	c. LENGTH (OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
٥		Sykesvill		3.5	773ma 2	6 desce	_			14 V		_	
,		Sykesville 1 yrlmo_26 days Baltimore d. NAME OF HOSPITAL (If not in hospital give street address) OR (INSTITUTION) d. STREET ADDRESS								• 7		IS RESIDENCE	
	Springfield State Hospital 420 S. Lehig								Lehig	h St.			ON A FARM?
	3	NAME OF	E OF First Middle Lost & DATE Manus.									Day	Yeor
		DECEASED (Type or print)		Freder	rick	L.	MARKEL	SR.	OF DEATH	Aug	ust	19	19 57
	5. 5	SEX	6 COLOR OR RA	CE 7. MAR	RIED NEVEL	MARRIED [8 DATE OF BIRT	н		9. AGE (In years lost by thday)	IF UNDER		UNDER 24 HRS
	L.	Male	White	WIDOW	- 4.23	IVORCED []	Octobe			fy yn	Months	Doys H	lours Min
1	10a	USUAL OCCUPATION duffing most of work	N (G ve kind of wo	ork done 10b.	KIND OF BUS	INESS OR INDU	STRY F1. BIRTHP			ountry)			WHAT COUNTRY
1		- 100 A			ETH.ST	EEL C		-	rland			J.S.A.	•
	13.	John Mark	•1				14 MOTHER			-6-6-			
	15			ECRCECO ILA	COCIAL CECU	117 10 117 1		ary c.	Horn	Add			
,	LYes	15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Springfield Hospital Respiratory NO 18 Pringfield Hospital Respiratory NO 19 Pringfield Hospital Respirat											
			NA CEnter column		no fee (a) (b)		h+ #mgr T	ord	Sproa	I NECOIG		LINISCOV	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Infarction of myocardium due to arteriosclerotic Instant Light Coronary thrombosis											AND DEATH
													tant
	Conditions, if ony, which gove rise to immediate cause (a), sloting the under-									Von	-		
										rea	45		
		lying couse fost	ne under-		eralize	d arter	losclero	sis					
in.	<u>0</u>	C B S on	ER SIGNIFICANT C	OND TIONS	CONTRIBUTING	TO DEATH BUT	NOT RELATED TO	O THE TERM	NALD SEASI	E CONDITION G	VEN IN PAR	1 (a) 19.	WAS AUTOPSY PERFORMED?
J	C.B.S. assoc, with circ, dist., with cerebral arteriosclerosis, with psychotic reaction.										ES NO		
	CERTIFICATION	20s ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY I	CAUSE OF DEA	THI	CRIBE HOW IN	IJURY OCCURRE	D (Enter nature)	af injury in f	Port I ar Port	I II of item 18.)			
	CAL	20c. TIME OF INJURY	Month, Doy.	Year 20d. I	NJURY OCCUR		ACE OF INJURY	(Home, farm	, 20f (City	ar town)		Caunty)	(State)
	MEDICAL	Hour e.m.	1	While	Not while	e fa	clary, street, offic	e bldg., etc.			,	,,,	()
		21. I certify the	at Lattended i				3. 79.56	to At	ionat.	19. 1057	that I I	lest sour	the deserve
		alive on Aug	ust 19.	19						n the causes			
		1.1.	11111 08	1		1//	occorred di			reet, city or town.		ne dole	DATE SIGNED
1		ACTUAL NA	mur of	IMW	undu	NS_	MD. Sp	ringfi	eld S	tate Hos	oital		8/19/57
		PHYSICIAN'S NAME (Type) Wa	lther H.	Sonner	nfel/dt.	M.D.	Sv	keevil	3a. M	arvland.			
	22a	BUR AL, CREMATION				OF CEMETERY O				ION (City, town	or caunty)		(State)
		BURTAL	8-22		OAL	LAL		EM.	72.25		RN	SLN/1	
	23	FUNERAL DIRECTOR'S		90	ADDRES	11611	ALC. Sm	1		REGI			01
	V	starless	4 Herly	WE	ALT	0.24	MA	JOHN !	166	134.	(A	arre	Melya

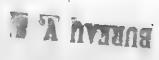
y the funeral director, TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be recogned by the haspital ar attending physician.

TO FUNER.

ARECTOR: After this certificate has been signed by the attending physician and campletely filled page 3 page 3 page 3 page 3 page 3 page 4 page 4 page 4 page 5 page 6 page 6 page 6 page 6 page 7 page

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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VS A15 (4) 15M 9/55

HEALTH-BALTIMORE, 1	8
	IEALTH—BALTIMORE, 1

08401 CERTIFICATE OF DEATH

(18403) eg. Dist. No.

									/		
١	1. PLACE OF DEATH o. COUNTY Ca	rroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. COUNTY Carroll							
y" "	b. CITY OR TOWN (I RURAL and give ne Sykesv	f outside corporate limite arest town) 111e		LENGTH OF STAY IN 16 mos. 17 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **X **I Hampstead**						
-	d. NAME OF HOSP IT OR INSTITUTION Springfie	AL (If not in hospitol, given the state of t	spital	ress]	d STREET ADDRE	SS			10	RESIDENCE N A FARM?	
	3. NAME OF DECEASED (Type or print)	First Ca	MexTERS	4. DATE OF DEATH	Augus		S, Doy	Year 19 57			
	5. SEX Female	1.73-2.4	7. MARRIED WIDOWED [April 10		AGE (In years lost bethday) 76 yrs.		YEAR IF U!	NDER 24 HRS.	
X	100. USUAL OCCUPATION during most of work HOUSEWII	N (Give kind of work di ing life, even if retired)	one 10b. KIN	D OF BUSINESS OR INDUS		State or foreign cou	intry)		ZEN OF WE	AT COUNTRY	
1	13. FATHER'S NAME John - LONG Nancy Long								•		
	15. WAS DECEASED EVER	R IN U. S. ARMED FORCE		MAL = 17. IF	Springfie	ld Hospita	Addr al Recor				
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic heart disease INTERVAL BETW ONSET AND DE Years										
	Conditions, if any, which gove rise to immediate couse (a), stoting the under the course (a), stoting the under the course (a), stoting the under the course (a) to the under the course (b).								Years		
	1ying couse lost. (c) (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS A PERFOR								AS AUTOPSY REORMED?		
	OR CONTRIBUTING	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
	20c. TIME OF INJURY Hour o. p. p. m.	Month, Day, Year 19	20d. INJUI While of work	Not while fac	CE OF INJURY (Home, tory, street, office bldg.	farm, 20f. (City o	r Iown)	(Co	iunty)	(Stote)	
	21. I certify that I attended the deceased from May 29, 1957, to August 16, 1957, that I last saw the deceased of alive on August 15, 1957, and that death occurred at 4:35A M, from the causes and an the date stated at								ne deceased ated above DATE SIGNED		
		Walther H.	Sonner	ifeldt, M.D.		lle, Mary		ar.		120/21	
	220. BURIAL, CREMATION	aug 19/	5-7 2	Meuch	CREMATORY	22d. LOCATIO	ON (City, town, or	county)	7/5	lote)	
	23. FUNERAL DIRECTOR'S	TINTON	Ham	ADDRESS 10 STEAD,		REC'D BY REGISTRA	AR 24b. REGIST	TRAR'S SIGN		w	

DE VIEW TO

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within 24 hours

HOSPITAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU K. S. 1367

BUREAU V.

DECENALED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08413 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. COUNTY b. COUNTY o. STATE MARYLAND b. CITY OR TOWN (It outside c. LENGTH OF STAY IN 1b c. CITY,OR TOWN (If outside corporate limits, write RURAL and give negrest town) and give negrest town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE YES NO 3. NAME OF DECEASED (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED DE 8. 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. fast birthday) Months Days Min. WIDOWED [7] DIYORCED yrs. TOg. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS, OB INDUSTRY 112. CITIZEN OF WHAT COUNTRY? during post of working life, even if ratired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT nous CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN DINSET AND DEATH I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate cause **DUE TO** (a), stating the underlying couse tost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINALD SEASE CONDITION GIVEN IN PART I(D) 19, WAS AUTOPSY PERFORMED? NO [20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of Item 18.) PRIMARY | or CONTRIBUTING | 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Hame, farm, 1 20f. (City or fawn) Month, Day, Year (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while at work at work p. m. 21. I certify that I took charge of the remains described above, held an Autopsy 🔀 Inspection inquiry [and find that Suicide X Homicide . Undetermined cause DATE SIGNED ACTUAL -GHIEF MEDICAL EXAMINER SIGNATUR ASSISTANT MEDICAL EXAMINER **EXAMINER'S** TUPED NAME (Type) DEPUTY MEDICAL EXAMINER CREMATION. 22d LOCATION (City, town, or county) 5 5 0 24b. REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR YS. A15ME(5) 5M 9/55



BUREAU V. S.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

8 (18407 Reg. Dist. No. 744

	·								
	1. PLACE OF DEATH COUNTY	oll	MARYLAND	o STATE Maryland D. COUNTY Montgomery					
	b. CITY OR TOWN (If outside RURAL and give negres) to Sykesville		11mos.3days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
	d NAME OF HOSPITAL (IF I	ot in hospitol, give street of State Hospi	oddress)	d STREET ADDRESS 721 Dale D					
	3. NAME OF DECEASED (Type or print)	First	Middle n Shackleton	ROBINSON	4. DATE Month OF DEATH August	Day Year 13. 1957			
-			IED NEVER MARRIED	B. DATE OF BIRTH June 27. 188	9. AGE (In years If lost birthday)	FUNDER TYEAR IF UNDER 24 HRS Months Days Hours Min.			
1	during most of working life	e kind of work done 10b. even if retired)	KIND OF BUSINESS OR INDU		or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
1	13. FATHER'S NAME			14. MOTHER'S MAIDEN N	AME				
	Ben Shacklet	on		Anna All	en				
^	15 WAS DECEASED EVER IN U (Yes, nd or unknown) If yes, w		70 02 2226	nformant Springfield Ho	Address spital Records	3			
	Conditions, if ony, wh gove rise to immedicate (o), stating the unitying couse lost PART II. OTHER SIG C.B.S. ASSOCE DSYCHOLIC 200 ACCIDENT WAS UND OR CONTRIBUTING CA (IF EITHER, NOTIFY MEDIC TO THE OF INJURY MO Hour o. m. p. m	SCAUSED BY. DIATE CAUSE (o) DUE TO Sich one one office DUE TO (c) Ge INIFICANT CONDITIONS C WITH CITC di TEACTION DEETYING D USE OF DEATH AL EXAMINER) Onth, Doy, Year While of work Attended the decease	conchopneumonial teriosclerotic eneralized arteriosclerotic eneralized arteriosclerotic eneralized arteriosclerotic eneralized arteriosclerotic eneralized arteriosclerotic eneralized eneralized eneralized energy of the energy	c heart diseas priosclerosis I NOT RELATED TO THE TERMIN pral arteriosc abscess. DO. (Enter noture of injury in Proceedings) ACE OF INJURY (Home, form, ictory, street, office bldg., etc.) 1956, to Au accurred at 11:45	PAL DISEASE COND TION GIVEN lerosis, with ort I or Port If of Item 18.) 20f (City or town) Bust 13, 19.57. AM, from the causes and ADDRESS (Street, city or town, sto	- 4 4 4			
	SIGNATURE VA AVA	1ther H. Son	,		ld State Hospit e. Maryland	AL 0/13/5/			
	220 BURIAL, CREMATION, 22		ROCK CREEK C	OR CREMATORY EMETERY	22d LOCATION (City, town, or WASHINGTON				
	23 FUNERAL DIRECTOR'S SIGN	IATURE 1	ADDRESS Silver	Jarens 240. REC'D	BY REGISTRAR 246 REGISTE	RAR'S SIGNATURE			

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·c. 911.

DECENTED

BUREAU V. E.

HOSPITAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

E. TO V. S.

WEGEN SEW

			08407 CERTIFICA	ATE OF DEATH	Reg. Dist. No. \$2 33
al director,		L	LACE OF DEATH COUNTY Arrol MARYLAND CITY OR TOWN (If outside corporate limits, write c, LENGTH OF STAY IN 1b	2. USUAL RESIDENCE [Where deceased lived. If institute a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write is	Carroll
the funera shauld be			RURAL and give nearest fown) 2 10 11 11 11 11 11 11 11 11 1	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
filled into			Home First Middle First Middle First Middle First Middle Mau Mau	Smith DEATH AUgu	th Day Year
I campletely filled papers. Pages I eath.	1	5. :	Femaly 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH December 20/887 (git birthday) (69 yrs	Months Days Hours Min
o and I have	-1	L	USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDU during most of working life, even if retired) HOUSE WIFF ATHER'S NAME	Mary land	12. CITIZEN OF WHAT COUNTRY?
physician remove ca 2 hours aft			Matthew MUVVay NAS DECEASED EVER IN U. S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I NO OF Minnown) NONE NONE	Susan Molesu Informant Add John D. Smith M	
attending n please it within 7		-	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: MMEDIATE CAUSE (a) C. OY CINO	C C1 1	INTERVAL BETWEEN ONSET AND DEATH MOVE THEM
ed by the frmit. The			Conditions, if any, which gove rise to immediate DUE TO		6 months.
ysicion. ysicion. been sign fronsit	2	TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIV	VEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
AN: the		CERTIFICA	OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Part I or Port II of item 18.)	YES NO
tol or oth this certif or use as remofian,		MEDICAL	20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED to form a. p., p. m. 19 While at wark at wark	ACE OF INJURY (Home, form, 20f, (City or town) ctary, street, office bldg., etc.)	(County) (State)
the hospi The hospi TR: After etocited for			21. I certify that I attended the deceased from October alive on August 7, 1257, and that death		I, that I last saw the deceased and on the date stated above.
fained by	/		PHYSICIAN'S NAME (Type) W.B. CUlwell W.B. CUlwell	M.D. Mount Airy	Aug 9,195
may be re FUNER page 3 s		220	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY O	or CREMATORY 2d. LOCATION (City, fown, Long Corne	
YS A15 (4) 15M 9/\$5	`	23.	Plin L'Holeworth Damascus	240, REC'D BY REGISTRAR 24b, REGI	STRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08410

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

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DECENALD

P. S.		084')9 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1841)2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
A.J.	1_	Item 7, Film G219,
DE S	1,	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) 5. COUNTY 6. COUNTY 7. TATE 7. T
	_	Carroll Maryland Carroll
		b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest fown) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)
		Cedarhurst Cedarhurst
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RES DENCE ON A FARM? YES \(\sum \no \cong \)
	3.	NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED (Type or print) CLARENCE C. TRUMP SR. DEATH August 19 19 57
8	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years igns builded?)
	/L	Male White WIDOWED DIVORCED Aug. 4, 1886 71 yrs. Months Days Hours Min
	1 10	2. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY during good of working life, even if retired)
	ŀ	during good of working life, even if retired) congleoum Nairn Md. U.S.
	13	. FATHER'S NAME
		John Wesley Trump Annie Houck
		. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address 216-07-4211 Mrs. Annie Teump Cederburgt Md.
/		The state of the s
		1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSEL AND DEATH
		PART I. DEATH WAS CAUSED BY: MMEDIATE CAUSE (0) Fractured Neck
		900.0 DUE TO
V		Conditions, if ony, which (b)
		(c), stoling the underlying course lost.
	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
2	CERTIFICATION	YES NO [
	I	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) PRIMARY M or CONTRIBUTING CAUSE OF DEATH. CAUSE OF DEATH.
		CAUSE OF DEATH. Fell down stairs.
	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote)
	MED	2:15 xxx 8/19 157 While of work 12 Home Codarhurst Carroll Md.
		21. I certify that I taak charge of the remains described above, held an Autapsy 14, Inspection 1, Inquiry 1, and find that
		death resulted from: Natural causes, Accident , Suicide , Hamicide , Undetermined cause .
		(1, 16 9)
2		SIGNATURE ADD. CHIEF MEDICAL EXAMINER []
		ASSISTANT MEDICAL EXAMINER \$\(\text{T}\) 8/19/57
		EXAMINER'S NAME (Type) Paul F. Guerin, M.D. DEPUTY MEDICAL EXAMINER
	22	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Iown, or county) (Stote)
		Burial August, 2257 Finksburg Cem. Finksburg Carroll Co.Md.
	23	FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240, REC'D BY REGISTRAR 246, REGISTRAR'S S GNATURE
		J.F. Eline & Sons, Reisterstown. Md. DATE 8-20-57 Mora S. Shine.
N. Carlotte	-	Harriet Millern

o v Ualing

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DEALENER

1. PLACE OF DEATH

b CITY OR TOWN (Sykesville

d NAME OF HOSPIT OR INSTITUTION Springile

100 USUAL OCCUPATIO nousewi 13 FATHER'S NAME

IS WAS DECEASEDEVE no

> 18. CAUSE OF DEA PART I DEA

Conditions, if o

gove rise to couse (o), sloting

lying couse lost.

CERTIFICATION

MEDICAL

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3. NAME OF

S. SEX

DECEASED (Type or print)

MARYLAND	STATE DEPARTM	ENT OF HEALTH	-BALTI	MORE, 1	8	0.0	4.4.0
08410	CERTIFICA	ATE OF DEATH	1		Reg. Dis		413
roll	MARYLAND	2. USUAL RESIDENCE (Who state Maryland	ere deceased li	ved. If institution b. COUNTY	n: Residenc		nission)
f autside carparate limits, write arest fawn]	c. LENGTH OF STAY IN 16 2 mths 19 day	c CITY OR TOWN (If or		e limits, write RL	JRAL and g	ive nearest to	own)
At (If not in hospital, give street of State Hospital		d STREET ADDRESS	Street			ON	RESIDENCE A FARM?
First Marrie	Frances Den		4. DATE OF DEATH	Mont 8		00y 24	Year 19 57
WIDOWE	ED DIVORCED	12-10-1890		fost birthdoy) 66 yrs.	Months.	Doys Hou	rs Min.
DN (Give kind of work done 10b. ung life, even if retired) [C	KIND OF BUSINESS OR INDUS	Maryland	1	itry)		S.A.	AT COUNTRY?
nelius Derr		14 MOTHER'S MAIDEN N Mary Met					
If yes, give wor or dotes of service)		NFORMANT .S.Hospital Re	cords	Addr	011		
TH [Enler only one couse per lin TH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO	ne for (e), (b), and (c).} ticemia due to	Decubitus Ulc	ers			INTERVAL ONSET AN Weeks	ND DEATH
the under-							
IER SIGNIFICANT CONDITIONS CONDITIONS CONDITIONS CONDERLYING CONDESSED CONDITIONS CONDIT		with psych re	act.Pa	rkinson		PER	S AJTOPSY FORMED?

PART II OTI C.B.S.as

200 ACCIDENT WA (IF EITHER, NOTIFY

20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED Hour e. m. While Not while al work Ol work p. m. 21. I certify that I attended the deceased from

August 24,

PUNERAL DIRECTOR'S SIGNATURE

20e. PLACE OF INJURY (Home, form, 20f (City or town) factory, street, office bldg., etc.)

(County)

8-24-1957 that I last saw the deceased and that death accurred at 9:40 M, from the causes and an the date stated above. ADDRESS (Street, city or town, stota) DATE SIGNED Springfield State Hospital

ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)

Sykesville, Md.

(Stote)

[Stole]

Edmund Lusthaus 220 BURIAL CREMATION. 22c. NAME OF CEMETERY OR EREMATOR)

22d OCATION (City, town, or county)

246 REGISTRAR S SIGNATURE

VS A15 (4) 15M 9/SS

BUREAU V.

DECENDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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BUREAU V. S.

VS A15 (4) ISM 9/55 13

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MARYLAND	STATE DEPARTMENT	OF HEALTH-	-BALTIMORE,	18
0 0				

08413 CERTIFIC

CERTIFICATE OF DEATH

08416 Reg. Dist. No. 7#

	1. PLACE OF DEAT	н		MARY		2. USUAL RESID	ENCE (Wh	ere deceased h	ved. If instituti		e before ad	mission)
	Ca	Maryland Carroll										
,	RURAL ond gr	b CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) Sykesville 9yrs.2mos.15d				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) ays Westminster						
Α	d NAME OF HO OR INSTITUTE Spring.	d NAME OF HOSPITAL (If not in hospital, give street oddress) By institution Springfield State Hospital -										RESIDENCE N A FARM? NO [3]
	3. NAME OF DECEASED (Type or print)	Edv	vard	Middle		WELLS		4. DATE OF DEATH	Augu		25,	Yeor 1957
	5. SEX Male	6. COLOR OR RACE White	7. MARRIE			Sept. 17			AGE (in years last b ribdoy) yes		YEAR IF UI	NDER 24 HF5 FS Min.
1	100 USUAL OCCUI	during most of working life, even if retired)									S.A.	IAT COUNTRY?
	13. FATHER'S NAME Edwar	d D. Wells, N	1.D.			14. MOTHER'S Mary		AME ephine l	Mathias			
0	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT NO (II) yes, give you or or dates of service) NO Springfield Hospital Records											
		DEATH [Enter only one or DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c DUE TO	, Car	for (o), (b), and (c)] reinoma of		stomach	1				INTERVAL ONSET A Mont	BETWEEN NO DEATH NS
	gave rise to couse (o), sto lying couse (1)									
2)	3 Mental	Mental Deficiency, Imbecile Level.										
		WAS UNDERLYING TING CAJSE OF DEATH TIFY MEDICAL EXAMINER	206. DESCR	BE HOW INJURY OF	CURRED	(Enter noture of	injury in P	ort I or Port II	of item 18)			
	Hour e.	NURY Month, Day, Ye m. m 19	at 20d INJ While of work	Nat white	20a PLA fact	CE OF INJURY (I ory, street, office	lame, form, bldg., etc)	20f (City or	tawn)	(Co	ounty)	(State)
	21. I certify alive on A	that I attended the ugust 25.	12_5	ond that	deoth	, 19.50 occurred of	5 * 30F	M, from t	he couses of the couse of t	ond on th	ost saw the	ne deceosed ated above.
1	ACTUAL SIGNATURE	Walther of	-Jor	mentelel	5~	o. Spri			te Hosp			8/26/57
	PHYSICIAN'S NAME (Type)	Walther H.						e, Mar			w	the life due law, on, then side was seen you. A
	220 BUR AL, CREM REMOVAL (SOE BULL 18.1	AT ON, 226 DATE THEREC		St. Joh					tminst		,	itote)
	23 FUNERAL DIREC			ADDRESS			24a REC'D	BY REGISTRAL	24b REGI	STRAP'S SIG		
	Jonn	R. Byers	West	minster,	Md	•	DATE 8	26.50	60	mry	auc	w

BUREAU V. S.

BEGEIVED.

08414 Wildasin CERTIFICATE OF DEATH Rea. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY Carroll o. State vland periled b. COUNTY MARYLAND Carroll death. b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) Lafe Rural. Nr. Westminster I.r. etminster d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS Livers District e. IS RESIDENCE ON, A FARM? Lyers District) Westminster, Md. R.D.1 kd. R.D.1 Westminster. YES NO NAME OF First 4. DATE Month Year DECEASED Catherine Wildisin August 21. Emma. (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years lost birthday) Months Femalle. White July 19, 1880 WIDOWED** DIVORCED [7] 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? Housework Housework U.S.A. Her own home Carroll Co. Md. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Josiah Wantz Catherine Roser 17. INFORMANT JAM FRENE KLIMB. IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Address Mrs. Irene Kump, Westminster, Md. R. D. 1 Νo None 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSELAND DEATH erotic rteriosci Hoder DUE TO Tenovalized Arteriosclerosis Conditions, if any, which gove rise to immediate **DUE TO** casse (o), stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? eacurvation YES NO TO 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Day, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) e. m. While Not while at work of work p. m. 1957, that I last saw the deceased 21. I certify that I attended the deceased from FT G. G. and that death occurred at I_A_M, from the causes and on the date stated above. ADDRESS (Street, city or town, stole) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) may be SFUNER 220 BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) Mr. Taneyton, בתדייות Piney Creek Brethern Cem Carroll IERAL DIRECTOR'S SIGNATURE **ADDRESS** Littlestown, Pa. 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARY AND STATE DEVALUATION OF REMITS CHAPTED TATE ON A PERMITS 25EP 8 1957 park. ,

FOR STATE HEALTH DEPT.

director. Page for your files.

DEFUTY MEDICAL EXAMINER: This certificate should be executed within II hours after death. If any delay is exute 15.7 certificate, withing the ward "pending" in pencil in 11em, 18. Give Pages 1, 2, and 3 to the further of forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained. The construction of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained. The control of the contro

08380

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

	0841	9
Reg.	Disf. No.	1

1.	PLACE OF DEATH G. COUNTY CARROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Re o. STATE MARY AND b. COUNTY	ridence before admission)
-	b. CITY OR TOWN III outside corporate limits, write RURAL C. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL	and give negrest town)
	WEST MINSTER VEARS	27 WESTMINSTER	
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	d. STREET ADDRESS	e IS RESIDENCE
	335 E MAIN ST	335E MAIN ST	YES NO NO
3.	NAME OF DECEASED (Type or print) ANNA REBECCA	WOLFE OF DEATH AUG	25 1957
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18 8. WIDOWED DIVORCED 1	MAY 20 - 1873 9. AGE (In years IF UND Months	PER TYEAR IF UNDER 24 HRS. Doys Hours Min.
10	To. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUST during most of working life, even if retired)	RY 11. SIRTHPLACE (Stote or foreign country) 12. (CITIZEN OF WHAT COUNTRY?
L	SCHOOL TEACHER TEACHER	MAKYLHND	484
13	3. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
11	5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. IN	SUSAN MAINES	
1x	5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN 19. no. or unknown) (II yes, give wor or dates of service)	NOLFE WESTMIN	STER
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	4	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CHUSED BY: U.S. C. V. d	uene_	years!
	42.1 DUE TO		/
	Canditions, if any, which (b)		
	(a), stating the underlying DUE TO		
-	cause last. (c)		
CATION	PART 11, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	IOI RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN P	PERFORMED? YES NO
CERTIFICATION		infer nature of injury in Part I at Port II of item 18.)	
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE	CE OF INJURY (Home, form, 20f. (Cily or town) (ory, street, affice bldg., etc.)	County) (State)
MED	Hour a.m. While Nol while p. m. 19 of work at work	ory, street, united blogs, etc.)	
	21. I certify that I took charge of the remains described abo	ve, held an Autopsy [], Inspection [X], Ing	uiry ond in my
	opinion deoty resulted from: Notural causes X. Accident	, Suicide , Homicide . Undeterminer	manner 🔲
	1 (1 11 11 1)		
	SIGNATURE ALLIES J. MOTO	M.D. CHIEF MEDICAL EXAMINER	DATE SIGNED
	EXAMINERAS.	ASSISTANT MEDICAL EXAMINER	8/21/-
	NAME (TYDE) VAMES 1. IVIARSH	DEPUTY MEDICAL EXAMINER	0/26/27
22	20. BURTAL CREMATION, 226. DATE THEREOF 72c NAME OF CEMETERY OR	CREMATORY 22d. LOCATION (City, lown, or county	(Slote)
	SUBJAL HUG 37-1931 MT VIE	UKION BRIDGI	- 110
23	EUNERAL DIRECTOR'S SIGNATURE ADDRESS	0.00 0.0	SIGNATURE 11 //
1	A IN MINULATION MANION HALLAN DA	MAR DATE SO DE TO	- 11111/

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BUREAU V. E.

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